Forward Choices, LLC

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Screening Information

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Readmit: **Yes** **No**

Date________________

Client's First Name________________________________ Last Name________________________________ MI______

Address____ City_________________________ State_________ Zip____________

Telephone (Home)____ (Work)____

Email ____ Birth date _____/___/______ Age______________

Gender __F __M Race____

Name of Spouse/Guardian____ Phone________________

Address____ City_________________________ State_________ Zip___________

Person Responsible for Payment____ Soc. Sec. #____________________________

Signature of Person Responsible for Payment **X**____Date: __________________

(Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) ____ Relationship_________________ Phone_______________

Address____ City_________________________ State_________ Zip____________

Name (2) ____ Relationship_________________ Phone_______________

Address____ City_________________________ State_________ Zip___________

Physician____ Phone_______________

Address____ City_________________________ State_________ Zip___________

Psychiatrist____ Phone_______________

Address____ City_________________________ State_________ Zip___________

Other Physicians____ Phone________________

Current Medications____

Allergies____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place____ Phone________________Hrs____________

Spouse: Place____ Phone________________Hrs____________

Insurance Information

Primary Insurance_______________________________________

Phone____

Contract/ID#____

Group/Acct#____

Subscriber____

Subscriber Date of Birth ________________________

Client's relationship to Subscriber

__Self __Spouse __Child __Other_______________

Secondary Insurance______________________________

Phone____

Contract/ID#___________________________________

Group/Acct#____________________________________

Subscriber_____________________________________

Subscriber Date of Birth__________________________

Client's relationship to Subscriber

_Self __Spouse __Child __Other_________

Referral Source

How did you hear of our clinic (or from whom)?____

Address____ City________________ State_________ Zip___________

Phone_________________ Relationship to referral source____